

Thank you for reviewing our draft patient guide. We greatly appreciate your time and insights.

Once we collect all feedback, our writers and designer will edit the guide based on what we hear. This can include making it shorter and easier to read. To see an example of a final guide, please see our recent patient guide for [Low Back Pain](#). (Note: All guides may look different.)

When you're finished reading the draft patient guide, please fill out [this survey](#) by **May 14, 2019**.

IMAGE TBD

Going Home from the Hospital

Questions to ask your care team as you get ready to leave the hospital

Why is it important to talk with your hospital care team about your transition from hospital to home?

Going home from the hospital is a major step forward in your health journey, and a lot will change at this point. You'll leave your hospital routine, doctors, and care team—which can include nurses, physiotherapists, mental health workers, and volunteers—for care at home that could involve new medication, instructions and a different care team.

It's important for you and your family to play an active role in the conversations about your transition while you are still in hospital. Ask for time to ask questions and share any concerns. Finding out as much as you can before leaving the hospital will prepare you for the next phase of healing and help you avoid complications.

Write it down

Use this guide when you talk to your care team about your transition plan.

If you can, it helps to take notes while you're still in hospital. A friend or family member can also take notes for you while you talk to your doctors, nurses, or other care providers.

If you're a caregiver ...

You might have your own questions. And, you may want to identify yourself as the patient's caregiver to their hospital care team and make sure that they know and respect your concerns.

- Let them know what your role will be in the patient's care at home.
- Let them know if you're not available to provide care once they are home, or if you need help.

Ask about: how to get ready to leave

While in hospital, you'll want to start thinking about your transition home, starting with some general questions about how to care for yourself.

Ask your hospital care team:

When will I be sent home? What's the earliest day I should plan for?

Who is in charge of planning my transition home from the hospital?

Can I have copy of my transition plan? (This is a document that describes your diagnosis, hospital stay, your treatment, and your care and support plan once home.)

Once I'm at home, who should I contact if I have questions about my transition plan?

What do I need to know to care for myself at home? Will I need to change the dressing on a wound, or use new equipment? And if so, who will show me how to do this before I leave?

Tell your hospital care team:

Who you want to include in decisions about your transition plan (like a family member or friend)

If you don't have a place to go after leaving the hospital

If you don't have a ride home

If you need help getting to the lobby or to your car

If you might need extra help at home

If you have any other worries or concerns about leaving the hospital and managing at home

Did you know?

Going home is still part of the healing journey. While in hospital, your body is under extra stress: you might not sleep well, you're in bed for an extended period of time, and you may be in pain or overwhelmed by repeated tests or questions. It's normal to feel anxious, tired, or unwell even after you get home. Allow yourself some time to get back to full health once you're there.

Resource: Patient-Oriented Discharge Summary

The [Patient Oriented Discharge Summary \(PODS\)](#) outlines information you should be given when you leave the hospital. If your hospital is not yet using PODS in your discharge discussions, you can download and use this worksheet with your hospital care team. It was developed by health care professionals and patients and caregivers like you.

Ask about: your medication

Once home, you might need medications. Knowing exactly why, when, and how to take them will keep your recovery on track.

Ask your doctor or nurse while in hospital:

What medications will I need at home? What are they for? When and how should I take them?

What are the side effects? Will they affect any other medication I take?

Will I have pain? How much pain can I expect? How should I treat it and what should I do to manage it?

Tell your doctor or nurse in hospital:

If you're worried about how to pay for medication

If you need someone to help you manage your medication at home

Did you know?

While you're still in hospital, your support goes beyond health care: if you would like an interpreter to understand your doctor's instructions, peer support, religious services, or social workers to help you with transitions, they're available. They will work with you to help you understand your care and what to expect.

Ask about: home and community care

If you need them, support such as at-home visits from a nurse, social worker, or someone to help you bathe or prepare meals can help your recovery. Or, you might need other health services, like occupational therapy or physiotherapy, either at home or in a community clinic. The more you know about what's available, the more you'll be able to get the help you need.

Ask your hospital care team:

Will I need home care (such as at-home visits from a nurse or other health care provider) or personal support care (such as help with bathing, dressing or cooking?) How soon and how often will I receive this help? Who pays for these services?

Will I need equipment, such as a hospital bed, shower chair, raised toilet seat, walker, or oxygen tank? Where do I get this equipment? Who pays for it?

Is a home visit or phone call by a nurse and/or doctor an option?

If I have problems getting the right kind of care at home when I need it, who can I call?

Tell your hospital care team:

Whether you had home or community care services before your hospital stay

If you need extra help taking care of yourself at home

Whether someone will be at home to help you

If you don't think the services being offered to you are enough to support you

If you're a caregiver ...

Caring for a someone after their hospital stay means that their needs and schedules will overlap with your own. Ask the care team to let you know when the patient will leave hospital and what their care requirements will mean for you. Tell them if you have concerns about managing their care at home.

It's important to be honest with yourself about how much you can do. What are you physically, socially, and emotionally able to do to support the patient? Where do you need extra support or another caregiver to help?

You may also have questions for the patient's hospital care providers, such as:

- What peer support groups for caregivers are available to me?
- Do you know of any workshops, family therapy sessions, or other supports for caregivers?
- Do you know of any day programs or in-home respite care, that would help me to take breaks while I am caregiving?

Ask about: follow-up medical care

You might need to check in with your family doctor, a specialist or hospital clinic after you get home.

Before you leave the hospital, ask your hospital care team:

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Do I need to follow-up with my family doctor or a specialist once I am home?
Has an appointment been booked with them?

If I need to book the appointment, when should I book it? (For example, within a week, two weeks, or a month?)

If I have trouble getting to this follow-up appointment, is there somewhere I can get help with transportation?

What if I don't have a family doctor? Can you help me find one for my follow-up care?

Who can I call if I have other questions or concerns about my recovery?

Ask about: you and your life

Any illness or surgery takes you away from your regular routine. Going home gets you back to familiar surroundings, but things may not get totally back to normal right away.

Ask your hospital care team:

What symptoms are normal for my health condition? When should I call a doctor or other health care professional?

How long will it take to get back to my normal routine?

Will I be able to drive right away?

Are there any foods I should or shouldn't eat when I get home?

Should I start or stop certain exercises? Are there any activities I shouldn't do?

Tell your hospital care team:

If you can't go home for safety or other reasons

If you don't have some basic items—such as food, or heat—that you need at home

About the important aspects of your life—like work or school—that you'd like to get back to

For your reference: the quality standard in brief

Health Quality Ontario is committed to helping patients, health care providers, and organizations improve the quality of health care in Ontario.

We know that not everyone across the province receives the right care, every time. So, to help address gaps in care, we produce quality standards that outline **what quality care looks like** for specific conditions and situations, such as transitions from hospital to home. Quality standards are based on current best evidence and input from patients, caregivers, and health care providers.

This patient guide accompanies the quality standard on the transition from hospital to home.

If you're interested in the quality standard, below is a summary. To read more, you can [download it here](#).

Information-Sharing on Admission

For clinicians: When people are admitted to hospital, the hospital notifies their primary care and home and community care providers soon after admission via real-time electronic notification. The community-based providers then share all relevant information with the admitting team in a timely manner.

What this means for you

When you are admitted to the hospital, hospital staff should ask you:

- The name of your family doctor or nurse practitioner
- The name of any other health care providers you have outside the hospital, such as a home care nurse or therapist

The hospital should let these health care providers know you have been admitted to the hospital and give them information about the care you receive while you are there.

Your family doctor or nurse practitioner and your home or community care provider should share any important information they have about your health with the hospital. This communication will help make sure you receive the best possible care while you are in the hospital and when you leave.

Comprehensive Assessment

For clinicians: People receive a comprehensive assessment of their current and evolving health care and social support needs. This assessment is started early upon admission, and updated regularly throughout the admission process, to inform the transition plan and optimize the transition process.

What this means for you

Shortly after you are admitted to the hospital, a health care professional should ask you about:

- Your health
- Your ability to function at home and at school or work
- Any other issues that affect your health

This is called a comprehensive assessment. The people taking care of you in the hospital will use this information to make sure you receive the best possible care while you are in the hospital and after you return home.

Patient, Family, and Caregiver Involvement in Transition Planning

For clinicians: People transitioning from hospital to home are involved in transition planning and developing a written transition plan. If people consent to include them in their circle of care, family members and caregivers are also involved.

What this means for you

You should be involved in all decisions about your transition from hospital to home. This makes sure that your wishes, needs, and preferences are considered. If you want them to be involved, your family and caregivers can also be part of these decisions.

Patient, Family, and Caregiver Education, Training, and Support

For clinicians: People transitioning from hospital to home, and their families and caregivers, have the information and support they need to manage their health after the hospital stay. Before transitioning from hospital to home, they are offered education and training to manage their health care needs at home, including guidance on medications and medical equipment.

What this means for you

Your health care team should help you and your caregivers learn how to manage your care at home, including how to take medications and use medical equipment. Ask your care team for written instructions.

Please see pages 6, 7, and 9 for more information on medication, community care, and follow-up care.

Transition Plans

For clinicians: People transitioning from hospital to home are given a written transition plan (which can reside fully within the discharge summary), developed by and agreed upon in partnership with the patient, any involved caregivers, the hospital team, and the home and community care team, before leaving hospital. Transition plans are shared with primary care and home and community care providers within 48 hours of discharge.

What this means for you

Your health care providers should include you in decisions about your transition from hospital to home. If you agree, your family and caregivers should also be involved. Your care team should:

- Create a written “transition plan” for you that explains everything you need to know about leaving the hospital and your care at home

If you agree, your family and caregivers should also get a written copy of your transition plan. The plan should be easy to read and understand, and your care team should offer to explain it to you.

Please see pages 4, 6, and 9 for more information on leaving the hospital, medication, and follow-up care.

Coordinated Transitions

For clinicians: People admitted to hospital have a named health care professional who is responsible for timely transition planning, coordination, and communication. Before people leave hospital, this person ensures an effective transfer of transition plans and information related to people’s care.

What this means for you

When you are admitted to the hospital, a health care professional should:

- Identify the person who's planning your transition home. This person will work with you and your family and caregivers throughout your hospital stay to make sure you know what will happen and what you need to do when you return home

Medication Review and Support

For clinicians: People transitioning from hospital to home have medication reviews on admission, before returning home, and once they are home. These reviews include information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered, and options are provided for those unable to afford these costs.

What this means for you

When you arrive at the hospital, a health care professional should:

- Ask you and your caregivers what medications you are taking

Before you leave the hospital, they should:

- Talk with you again in case any changes have been made to your medications and why, how to take them, and side effects you might experience
- Ask if you have any concerns about paying for your medications and help to find options for you if you aren't able to afford the cost of your medications

Once you are home again, another health care professional—like your family doctor or nurse practitioner, a home care nurse, or a pharmacist—should talk with you about your medications to make sure they fully understand your medication needs.

Coordinated Follow-Up Medical Care

For clinicians: People transitioning from hospital to home have follow-up medical care with their primary care provider and/or a medical specialist coordinated and booked before leaving hospital. People with no primary care provider are provided with assistance to find one.

What this means for you

Before you leave the hospital, your care team should:

- Arrange any follow-up care you need from your primary care provider or a specialist
- Give you clear instructions and contact information for this follow-up care

Please see page 9 for more information on follow-up care.

Appropriate and Timely Support for Home and Community Care

For clinicians: People transitioning from hospital to home are assessed for the type, amount, and appropriate timing of home care and community services they and their caregivers need. These services are arranged before people leave hospital and are in place when they return home.

What this means for you

If you need health care, personal support care, or assistance from other community services once you are back home, a care coordinator should:

- Work with you and your hospital care providers to arrange the services before you leave the hospital. (These services include things like home visits from a nurse or doctor to help with your medical care, help with preparing meals or cleaning, and help with transportation to medical appointments.)

Out-of-Pocket Costs and Limits of Funded Services

For clinicians: People transitioning from hospital to home have their ability to pay for any out-of-pocket health care costs assessed by the health care team, and alternatives for unaffordable costs are considered in transition plans. The health care team explains to people what publicly funded services are available to them and what services they will need to pay for.

What this means for you

Before you leave the hospital, a health care professional should:

- Let you know about any health or community support services you will need once you are home again
- Explain the services that require you to pay all or part of the cost, and options you can explore if you can't afford to pay for some services

What's next?

Remember, everybody is different.

The support you need and the transition plan you develop with your care providers in hospital and in the community will be unique to you.

This conversation guide is meant as only a starting point.

You may have other topics you want to cover with your care providers. It's important to speak to them about any other questions or concerns.

Need more information?

If you have any questions or feedback about this guide, please contact us at qualitystandards@hqontario.ca or 1-866-623-6868.

For more reading on transitions from hospital to home, read the quality standard at: hqontario.ca/qualitystandards

For more information, please visit: hqontario.ca

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